FOR OHF USE

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0035782

Facility Name: Winston Manor Cnv & Nursing

Address: 2155 West Pierce (Number) Chicago (City) 60622 (Zip Code)

County: Cook

Telephone Number: (773) 252-2066 **Fax #** (773) 252-3688

IDPA ID Number: 363671711001

Date of Initial License for Current Owners: 01/01/1990

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Sanford Alper **Telephone Number:** (773) 647-6600

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2000 to 12/31/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) Sanford Alper - Principal

(Firm Name & Address) Kessler, Orlean, Silver & Co. P.C.
7400 N. Oak Park Ave.
Niles, IL 60714

(Telephone) (847) 647-6600 Fax # (847) 647-7554

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 180

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	180	Intermediate (ICF)	180	65,880	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	180	TOTALS	180	65,880	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	61,068	462	81	61,611	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	61,068	462	81	61,611	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.52%

D. How many bed-hold days during this year were paid by Public Aid?
1,531 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/1990

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 1989 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified ____ and days of care provided 0

Medicare Intermediary Mutual Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2000 Fiscal Year: 12/31/2000

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	204,962	77,672	8,889	291,523		291,523	(326)	291,197			1
2	Food Purchase		155,365		155,365	(30,437)	124,928		124,928			2
3	Housekeeping	132,360	20,587		152,947		152,947		152,947			3
4	Laundry		3,804	8,352	12,156		12,156		12,156			4
5	Heat and Other Utilities			85,882	85,882		85,882		85,882			5
6	Maintenance	18,401		14,906	33,307		33,307	630	33,937			6
7	Other (specify):* See Attached Sch			14,420	14,420		14,420		14,420			7
8	**TOTAL General Services**	355,723	257,428	132,449	745,600	(30,437)	715,163	304	715,467			8
	B. Health Care and Programs											
9	Medical Director			1,950	1,950		1,950		1,950			9
10	Nursing and Medical Records	736,871	19,816	5,187	761,874		761,874		761,874			10
10a	Therapy			5,831	5,831		5,831		5,831			10a
11	Activities	51,462	10,314		61,776		61,776		61,776			11
12	Social Services	59,402		1,942	61,344		61,344		61,344			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	847,735	30,130	14,910	892,775		892,775		892,775			16
	C. General Administration											
17	Administrative	148,310		155,225	303,535		303,535	(155,225)	148,310			17
18	Directors Fees											18
19	Professional Services			107,067	107,067		107,067	(2,032)	105,035			19
20	Dues, Fees, Subscriptions & Promotions			26,264	26,264		26,264	(15,339)	10,925			20
21	Clerical & General Office Expenses	192,284	9,792	37,897	239,973		239,973	(11,647)	228,326			21
22	Employee Benefits & Payroll Taxes			235,140	235,140	30,437	265,577	11,642	277,219			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,280	1,280		1,280		1,280			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			49,582	49,582		49,582		49,582			26
27	Other (specify):*											27
28	**TOTAL General Administration**	340,594	9,792	612,455	962,841	30,437	993,278	(172,601)	820,677			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,544,052	297,350	759,814	2,601,216		2,601,216	(172,297)	2,428,919			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Winston Manor Cnv & Nursing #0035782 **Report Period Beginning:** 01/01/2000 **Ending:** 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			28,981	28,981		28,981	47,396	76,377			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes							236,591	236,591			33
34	Rent-Facility & Grounds			633,827	633,827		633,827	(633,827)				34
35	Rent-Equipment & Vehicles			11,337	11,337		11,337		11,337			35
36	Other (specify):*											36
37	**TOTAL Ownership**			674,145	674,145		674,145	(349,840)	324,305			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			98,240	98,240		98,240		98,240			42
43	Other (specify):* **Trust Fees**			250	250		250	(250)				43
44	**TOTAL Special Cost Centers**			98,490	98,490		98,490	(250)	98,240			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,544,052	297,350	1,532,449	3,373,851		3,373,851	(522,387)	2,851,464			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(3,516)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(326)	1		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(13,750)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(750)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(15,339)	20		28
29	Other-Attach Schedule See Schedule Attached	(80,079)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (113,760)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(408,627)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (408,627)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (522,387)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Winston Manor Cnv & Nursing

ID# 0035782

Report Period Beginning: 01/01/2000

Ending: 12/31/2000

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Trust Fees	$ (250)	43	1
2	Deferred Maintenance	630	6	2
3	Franchise Tax	(10)	21	3
4	Collections	(1,282)	19	4
5	Management Fees	(79,167)	17	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49				49
50				50
51				51
52				52
53				53
54				54
55				55
56				56
57				57
58				58
59				59
60				60
61				61
62				62
63				63
64				64
65				65
66				66
67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(80,079)		90

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Winston Manor Cnv & Nursing **#** 0035782 **Report Period Beginning:** 01/01/2000 **Ending:** 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(326)	0	0	0	0	0	0	0	0	0	0	(326)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	630	0	0	0	0	0	0	0	0	0	0	630	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	304	0	0	0	0	0	0	0	0	0	0	304	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(79,167)	(76,058)	0	0	0	0	0	0	0	0	0	(155,225)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,032)	0	0	0	0	0	0	0	0	0	0	(2,032)	19
20	Fees, Subscriptions & Promotions	(15,339)	0	0	0	0	0	0	0	0	0	0	(15,339)	20
21	Clerical & General Office Expenses	(13,760)	2,113	0	0	0	0	0	0	0	0	0	(11,647)	21
22	Employee Benefits & Payroll Taxes	0	11,642	0	0	0	0	0	0	0	0	0	11,642	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(110,298)	(62,303)	0	0	0	0	0	0	0	0	0	(172,601)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(109,994)	(62,303)	0	0	0	0	0	0	0	0	0	(172,297)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Winston Manor Cnv & Nursing** **#** **0035782** **Report Period Beginning:** **01/01/2000** **Ending:** **12/31/2000**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(3,516)	0	50,912	0	0	0	0	0	0	0	0	47,396	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	236,591	0	0	0	0	0	0	0	0	236,591	33
34	Rent-Facility & Grounds	0	0	(633,827)	0	0	0	0	0	0	0	0	(633,827)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(3,516)	0	(346,324)	0	0	0	0	0	0	0	0	(349,840)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(250)	0	0	0	0	0	0	0	0	0	0	(250)	43
44	**TOTAL Special Cost Centers**	(250)	0	0	0	0	0	0	0	0	0	0	(250)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(113,760)	(62,303)	(346,324)	0	0	0	0	0	0	0	0	(522,387)	45

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Marvin Mermelstein	75.00%	Balmoral Home, Inc.	Chicago, IL	Nivram Mgmt., Inc.	Chicago, IL	Nursing Home
Joseph Mermelstein	25.00%	Emerald Park Nursing Center	Evergreen Park, IL			Management
		Central Nursing Home, Inc.	Chicago, IL	Pierce Building Ptsp.	Chicago, IL	Lessor
		Sovereign Healthcare, L.L.C.	Chicago, IL			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		21	Bank Charges	$	Nivram Management, Inc.	50.00%	$ 10	$ 10	1
2	V		21	Office Expense		Nivram Management, Inc.	50.00%	69	69	2
3	V		21	Supplies		Nivram Management, Inc.	50.00%	1,485	1,485	3
4	V		21	Franchise Tax		Nivram Management, Inc.	50.00%	10	10	4
5	V		22	Payroll Taxes		Nivram Management, Inc.	50.00%	11,642	11,642	5
6	V		21	Telephone		Nivram Management, Inc.	50.00%	539	539	6
7	V		17	Management Fees	76,058	Nivram Management, Inc.	50.00%		(76,058)	7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ 76,058			$ 13,755	$ * (62,303)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	Depreciation	$	Pierce Building Partnership	50.00%	$ 50,912	$ 50,912	15
16	V	33	Property Taxes		Pierce Building Partnership	50.00%	236,591	236,591	16
17	V	34	Rent	633,827	Pierce Building Partnership	50.00%		(633,827)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 633,827			$ 287,503	$ * (346,324)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Henry Mermelstein	Administrator	Administrative	None	180,000	8	10.00%	Salary	$ 20,000	L17,C1	1
2	Louise Mermelstein	Dietary Supervisor	Supports	None	54,000	22	28.00%	Salary	21,000	L1,C1	2
3	Marvin Mermelstein	Plant Supervisor	Supports	50.00%	36,225	4	24.00%	Salary	12,075	L6,C1	3
4	Doreen Mermelstein	Administrative Asst.	Clerical	None	72,448	11	18.00%	Salary	17,113	L21,C1	4
5											5
6	Marvin Mermelstein	Asst. Administrator	Administrative	See Above	136,275	16	25.00%	Salary	45,425	L17,C1	6
7	Joseph Mermelstein	Owner	Administrative	50.0%	57,431	3	25.00%	Salary	22,570	L21,C1	7
8											8
9			See Schedule B								9
10											10
11											11
12											12
13								TOTAL	$ 138,183		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.**

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2000 Ending: 2/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Nivram Management, Inc.
Street Address: 2155 W. Pierce
City / State / Zip Code: Chicago, IL 60622
Phone Number: (773) 252-3208
Fax Number: (773) 252-3688

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Bank Charges	Resident Beds	942	5	$ 50	$	180	$ 10	1
2	21	Office Expense	Resident Beds	942	5	361		180	69	2
3	21	Supplies	Resident Beds	942	5	7,772		180	1,485	3
4	21	Franchise Tax	Resident Beds	942	5	50		180	10	4
5	22	Payroll Taxes	Resident Beds	942	5	60,925		180	11,642	5
6	21	Telephone	Resident Beds	942	5	2,823		180	539	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 71,981	$		$ 13,755	25

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 **Report Period Beginning:** 01/01/2000 **Ending:** 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	141,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	185,991	2
3. Under or (over) accrual (line 2 minus line 1).	$	44,991	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	191,600	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	236,591	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	134,134	8
	1996	135,873	9
	1997	156,540	10
	1998	136,928	11
	1999	185,991	12

1999 Tax Bill = 185,991
Est Increase = 1.03
Est 2000 Tax = 191,571 use 191,600

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 59,192 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 4

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home		1989	$ 105,000	1
2					2
3	TOTALS			$ 105,000	3

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	180		1989		$ 1,536,832	$	31.5	$ 48,779	$ 48,779	$ 542,775	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Security System			1990	9,200	292	31.5	292		3,176	9
10	Interior Imporvement			1990	32,039	1,018	31.5	1,018		10,727	10
11	Elevator			1990	5,300	168	31.5	168		1,757	11
12	Tiling & Lobby Office			1990	10,143	322	31.5	322		3,315	12
13	Building Imporvement			1991	3,230	103	31.5	103		977	13
14	Building Imporvement			1991	4,806	153	31.5	153		1,440	14
15	Tiles			1991	11,906	377	31.5	377		3,425	15
16	Radiator Cover			1992	12,400	394	31.5	394		3,464	16
17	Electrical Work			1992	3,500	111	31.5	111		967	17
18	Building Imporvement			1993	21,476	550	39	550		4,066	18
19	Building Imporvement			1995	34,754	891	39	891		4,938	19
20	Flooring & Tile			1996	5,355	137	39	137		622	20
21	Generator			1996	35,589	913	39	913		4,147	21
22	Air Conditioner			1996	16,511	423	39	423		1,922	22
23	Alarm System			1996	3,744	96	39	96		436	23
24	Roof			1996	1,200	31	39	31		141	24
25	Hot Water Heater			1996	2,900	74	39	74		336	25
26	Smoke Eaters			1993	4,600		10	460	460	3,450	26
27	Air Conditioner			1993	2,550		10	255	255	1,912	27
28	Carpet			1993	3,527		10	353	353	2,648	28
29	Boiler			1993	3,600		10	360	360	2,700	29
30	Air Conditioner			1994	5,122		10	512	512	3,328	30
31	Hot Water Heater			1995	4,160		10	416	416	2,292	31
32	Air Conditioner			1995	2,816		10	282	282	1,559	32
33	Glass			1995	647		10	64	64	320	33
34	Roof			1997	21,350	547	39	547		1,915	34
35	Phone System			1997	13,666	350	39	350		1,225	35
36	TOTAL (lines 4 thru 35)				$ 1,812,923	$ 6,950		$ 58,431	$ 51,481	$ 609,980	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Electrical Work			1997	49,685	1,274	39	1,274		4,459	9
10	Central Air Conditioning			1997	35,499	910	39	910		3,185	10
11	New Office Construction			1997	4,442	114	39	114		399	11
12	Boiler Insulation / Installation			1997	29,412	754	39	754		2,639	12
13	Fire Alarm and Sprinklers			1997	2,475	63	39	63		221	13
14	Doors and Construction			1997	8,191	210	39	210		735	14
15	Plumbing - Toilets, Pipes			1997	4,719	121	39	121		424	15
16	Roof			1998	3,900	100	39	100		250	16
17	HVAC Work			1998	2,700	69	39	69		173	17
18	Doors and Construction			1998	2,729	70	39	70		175	18
19	Time Clock			1998	5,244	135	39	135		238	19
20	Air Conditioner			1998	777	20	39	20		50	20
21	Phone System			1998	1,283	33	39	33		88	21
22	Door			1999	2,500		39	64	64	97	22
23	Fire Damper			1999	1,783		39	46	46	69	23
24	Water System			1999	6,000		39	154	154	231	24
25	Doors			1999	2,500		39	96	96	64	25
26	Kitchen Tiling			1999	10,250		39	263	263	394	26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 174,089	$ 3,873		$ 4,496	$ 623	$ 13,891	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 146,220	$ 16,709	$ 12,725	$ (3,984)	5-10 Yrs	$ 88,473	37
38	Current Year Purchases	7,246	1,449	725	(724)	5-10 Yrs	725	38
39	Fully Depreciated Assets	317,222					317,222	39
40								40
41	TOTALS	$ 470,688	$ 18,158	$ 13,450	$ (4,708)		$ 406,420	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 2,562,700	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 28,981	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 76,377	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 47,396	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,030,291	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 975 Description: Ice Maker
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Administrative	1996 Chrysler Van	$ 419.00	$ 5,022	17
18	Administrative	1996 Jeep Grnd Cherokee	445.00	5,340	18
19					19
20					20
21	TOTAL		$ 864.00	$ 10,362	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 259,063	$ 259,063	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 0)	492,785	492,785	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	95,451	95,451	7
8	Accounts Receivable (owners or related parties)	676,227	142,279	8
9	Other(specify):		718,236	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,523,526	$ 1,707,814	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		105,000	13
14	Buildings, at Historical Cost		1,536,832	14
15	Leasehold Improvements, at Historical Cos	423,158	497,863	15
16	Equipment, at Historical Cost	497,704	497,704	16
17	Accumulated Depreciation (book methods)	(518,400)	(1,077,601)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): Deposits	500	500	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 402,962	$ 1,560,298	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,926,488	$ 3,268,112	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 67,341	$ 67,341	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		141,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	1,271,770	1,271,770	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,339,111	$ 1,480,111	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,339,111	$ 1,480,111	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 587,377	$ 1,788,001	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,926,488	$ 3,268,112	48

***(See instructions.)**

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 **Report Period Beginning:** 01/01/2000 **Ending:** 12/31/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,218,388	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,218,388	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,547,313	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(2,150,000)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe) **RECORD 1999 STATE REPL TAX**	(28,324)	15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (631,011)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 587,377	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,812,364	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,812,364	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	987	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 987	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	15,758	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 15,758	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached Schedule E	92,055	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 92,055	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,921,164	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	713,500	31
32	Health Care	892,775	32
33	General Administration	995,916	33
	B. Capital Expense		
34	Ownership	673,170	34
	C. Ancillary Expense		
35	Special Cost Centers	250	35
36	Provider Participation Fee	98,240	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,373,851	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,547,313	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,547,313	43

*** This must agree with page 4, line 45, column 4.**

**** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. Entity is a Cash Basis Taxpayer.**

***** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,128	1,268	$ 33,394	$ 26.34	1
2	Assistant Director of Nursing	2,469	2,533	49,525	19.55	2
3	Registered Nurses	3,389	4,223	63,865	15.12	3
4	Licensed Practical Nurses	15,258	15,922	211,937	13.31	4
5	Nurse Aides & Orderlies	46,929	50,335	378,150	7.51	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,879	2,087	16,879	8.09	9
10	Activity Assistants	5,562	5,873	34,583	5.89	10
11	Social Service Workers	8,748	8,844	59,402	6.72	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,899	2,419	30,513	12.61	14
15	Cook Helpers/Assistants	19,799	21,895	174,449	7.97	15
16	Dishwashers					16
17	Maintenance Workers	2,984	2,992	18,401	6.15	17
18	Housekeepers	18,385	19,169	132,360	6.90	18
19	Laundry					19
20	Administrator	2,080	2,080	44,654	21.47	20
21	Assistant Administrator	4,160	4,160	83,656	20.11	21
22	Other Administrative	416	416	20,000	48.08	22
23	Office Manager					23
24	Clerical	10,950	11,482	192,284	16.75	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	146,035	155,698	$ 1,544,052 *	$ 9.92	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 8,889	L1, C3	35
36	Medical Director	Monthly	1,950	L9, C3	36
37	Medical Records Consultant	Monthly	1,568	L10,C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,457	L10,C3	39
40	Physical Therapy Consultant	76	3,048	L10A,C3	40
41	Occupational Therapy Consultant	40	2,944	L10A,C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	216	1,942	L12, C3	45
46	Other(specify)				46
47	Phyco - Social Consultant	Monthly	2,162	L10,C3	47
48					48
49	TOTAL (lines 35 - 48)	332	$ 23,960		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Arleen Batorek	Administrator	0.00%	$ 44,654
Marvin Mermelstein	Asst. Administr	75.00%	45,425
Henry Mermelstein	Administrative	0.00%	20,000
Phillip Morgenstein	Asst. Administr	0.00%	38,231
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 148,310

B. Administrative - Other

Description	Amount
Management Fees (Eliminated in Column 7)	$ 155,225
TOTAL (agree to Schedule V, line 17, col. 3)	$ 155,225
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
BLUEFINCH CORPORATION	Legal	$ 500
CALLAHAN FITZPATRCK	Legal	70
PURCELL & WARDROPE	Legal	18,418
ROSENTHAL & SCHANFIELD	Legal	19,267
SECO REFRIG, INC	Legal	2,500
TORSHEN, SPREYER	Legal	19,273
HOWARD REICH	Legal	750
ROSENTHAL & SCHANFIELD	Legal	15,656
PURCELL & WARDROPE	Legal	5,822
SEE ATTACHED	Various	24,811
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 107,067

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 57,921
Unemployment Compensation Insurance	12,490
FICA Taxes	95,979
Employee Health Insurance	51,459
Employee Meals	30,437
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Head Tax	3,654
Other Employee Benefit	13,637
Allocation from Management Comapnay	11,642
TOTAL (agree to Schedule V, line 22, col.8)	$ 277,219

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	15,339
Health Care Worker Background Check	112
(Indicate # of checks performed 16)	
IL Council on Long Term Care	8,228
See Attached	2,585
Less: Public Relations Expense	( )
Non-allowable advertising	(15,339)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,925

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,280
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,280

**See instructions.

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Deferred Maint - HVAC	June - 1998	$ 1,890	3 Yrs	$	$ 315	$ 630	$ 630	$ 315	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 1,890		$	$ 315	$ 630	$ 630	$ 315	$	$	$	$

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 **Report Period Beginning:** 01/01/2000 **Ending:** 12/31/2000

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Council on Long Term Care $8,228**

(3) Did the nursing home make political contributions or payments to a politica action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7.5 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line **N/A**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. $ **98,240**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes** If YES, attach an explanation of the allocation.

See Page 7

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Section B? **Yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
Mgmt. Co. leases office space; 5% utilities and office supplies are allocated.

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ **30,437** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Adequate Records are Maintained.**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.